TABLE OF CONTENTS

SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require prior authorization or medical necessity. The MRDD Home and Community Based Waiver Programs have unique documentation requirements beyond those outlined in Section 7, Medical Necessity or Section 8, Prior Authorization.

The documents discussed in this section are required for MRDD Home and Community Based Waiver Program compliance. The three MRDD Home and Community Based Waivers are the Comprehensive Waiver, Community Support Waiver and the Missouri Children with Developmental Disabilities Waiver, which is referred to as the Sara Jian Lopez Waiver.

14.1 EVALUATION OF NEED FOR ICF-MR LEVEL OF CARE AND ELIGIBILITY FOR THE MRDD HOME AND COMMUNITY BASED WAIVERS

Service Coordinators, employed by a DMRDD Regional Center, Affiliated Community Service Provider (ACSP), or a County SB-40 Board approved by DMRDD to provide Targeted Case Management, qualify to perform initial evaluation of level of care for waiver applicants. The level of care determination is approved by a DMRDD Regional Center and is subject to the approval of the State Medicaid Agency. The case manager gathers collateral information and assures social history and medical information is current. The case manager ensures the results of any testing or previous habilitative program experience is summarized. Any additional professional assessment necessary for determining level of care or program planning will be requested by the case manager. The case manager completes a functional screening instrument designed to provide general information on activities the person is able to perform alone, and those activities the person requires assistance in performing. Any types of adaptations and supports in use are noted.

The Missouri Critical Adaptive Behaviors Inventory (MOCABI) is the instrument used for adults and for older children when appropriate. Regional centers determine other age appropriate instruments such as the Vineland Adaptive Behavior Scales (VABS) that will be used for younger children. Based on the MOCABI, VABS, or other appropriate instrument, and on observation, interviews, collateral information and assessments, the case manager must document information indicating the person has mental retardation and/or a developmental disability which meets the federal definition of a "related condition". The case manager must also describe limitations the person has that would require active treatment in an ICF/MR facility and must explain why the person is at risk of entering an ICF/MR facility.

Based on the outcome of this evaluation, the individual may be admitted into the waiver. This process is analogous to the initial level of care assessment performed for the ICF/MR program using Department of Health and Senior Services form DA-124 A/B, but is more appropriate to the assessment of persons who have developmental disabilities.

REEVALUATION OF LEVEL OF CARE

Case managers, employed by a DMRDD Regional Center, or a County SB-40 Board approved by DMRDD to provide service coordination, are responsible for reevaluating each waiver participant as part of the annual person-centered planning process for continued need of an ICF/MR level of care. The reevaluation includes updating of all assessments on which the previous evaluation was based, including the MOCABI, and re-documentation of conditions of eligibility as listed above. Reevaluations of level of care by case managers employed by County SB-40 Boards or Affiliated Community Services Providers (ACSP) *must* be approved by a DMRDD Regional Center. All decisions are subject to approval of the Medicaid Agency. Ensuring the reevaluation is done annually and maintaining copies of the initial evaluation, all assessments and subsequent reevaluations is the responsibility of the DMRDD Regional Center or County SB-40 Board that is providing service coordination. This further includes tracking the number of annual re-determinations conducted on all waiver participants, the number of individuals who continue to be found eligible, and the number ineligible. Each agency must forward a quarterly aggregate report summarizing this data to the Statewide Quality Assurance Team member for their region, and this team member will assure compliance with this process as well as implementing any necessary corrective action.

14.3 FUNCTIONAL ASSESSMENT AND PLAN OF CARE (PERSON CENTERED PLAN)

The interdisciplinary planning team will include the individual and his representatives, family or guardian. The individual will choose whom he/she wants to attend as a member of the team, unless the individual is a minor or has been judged incompetent, in which case the family or guardian must attend. The team will also include a case manager and providers selected by the individual and other professionals involved with the individual may be included as applicable and at the individual's invitation. The plan is usually facilitated by a service coordinator employed by a DMRDD regional center or an approved County DD Board. If the person so chooses, another facilitator may be used, but the service coordinator will participate in the planning.

No later than 30 days from the date of acceptance into the waiver program, an interdisciplinary planning team will develop a person centered plan with the individual. Initial plans must contain a personal profile for the person, including what the person sees as important in relationships, things to do, places to be, routines, and immediate needs – especially those important to the person's quality of life, including health and safety and services and supports to meet his or her needs. Each action item in the plan should contain enough detail and/or examples to insure persons new to the individual can best support the person. If the initial plan is not comprehensive, it shall only last up to 60 days, and a more comprehensive plan needs to be finalized.

This plan will be based on the case manager's functional assessment of the individual, all other assessments that are pertinent, and the observations and information gathered from the members of

the team. Missouri uses the MOCABI functional assessment tool for adults and the VABS or other age-appropriate tools for children. This plan will be based on the case manager's functional assessment of the individual, all other assessments that are pertinent, and the observations and information gathered from the members of the team.

The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not . It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.

Upon being determined eligible for DMRDD services, each individual and/or legal representative, or guardian receives information regarding available services and programs, including information about the waiver. After needs are identified through the planning process, the service coordinator reviews this information once more and together with the individual, and the interdisciplinary team specific services and supports are identified to meet the participant's needs.

DMRDD Directive 4.050 describes the process service coordinators must follow when developing a person centered plan. Plans must be written in accordance with the DMRDD Personal Centered Planning Guidelines and Missouri Quality Outcomes. The Person Centered Planning Guidelines include a description of mandatory plan components: Demographics, health and safety, who are what are important to the person, what staff needs to know to do to provide support, requirements of the family of a minor child or guardian, how the person communicates, and issues to be resolved. These guidelines contain criteria for action plans including standards for developing outcomes and action steps.

The plan specifies all the services and supports that will be needed, and who is to provide them, to enable the individual to live the way he/she wants and learn what (s)he wants to learn. These methods may include teaching, which does not have to be behavioral. Learning can be incidental as long as it is planned. Providing supports or making adaptations to the environment may be part of the plan. The plan will also specify any limitations the planning team foresees in being able to support the individual in achieving these desires. Such limitations can be financial, temporal , and/or can relate to health and safety. DMRDD person centered plans address all supports and services an individual is to receive. This includes services through the waiver, other state plan services, and natural supports. For each need that is expressed, the plan must describe what support or services is being provided to meet the need. Each outcome in the plan must be accompanied by information regarding the person(s) responsible for assuring progress. Timelines for completion of each outcome is specified.

DMRDD service coordinators are responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

The case manager and individual and/or his/her representative will sign the completed plan. All members of the planning team will be provided a copy of the completed plan as appropriate. Person centered plans are subject to continuous revision. At a minimum, the entire team performs a formal

review at least annually. The service coordinator maintains at least quarterly contact for each individual, their family or guardian. Face to face contact is required for persons in residential placement and at least annually for persons who live with their family.

14.4 UTILIZATION REVIEW PROCESS

All person centered plans are subject to DMRDD utilization review/approval process as per 9 CSR 45-2.017. The purpose of the utilization review/approval process is to:

- Enhance quality of services and the service delivery system;
- Ensure fairness and consistency statewide;
- Ensure accountability for taxpayer dollars; and
- Stretch limited MRDD resources.

14.5 PRIOR AUTHORIZATION

Before delivering any waiver service, the provider *must* receive prior authorization approval from the DMRDD Regional Center. The DMRDD has an automated prior authorization and billing system. The waiver service provider can use an IBM compatible personal computer and modem to dial-up to the DMRDD Regional Center's computer. Once linked, the provider is able to view a screen that authorizes the specific service, rate and quantity the provider is approved to deliver for a specific period for each individual that they have been approved by the Regional Center to serve. Waiver providers are given access to the automated system and instructions on its use by the Regional Center

14.6 INDIVIDUAL PLAN OF CARE

The Individual Plan of Care (IPC) is an automated document derived from and supported by the Person Centered Plan (PCP). DMRDD Regional Centers use an automated system that allows case managers to request services identified through the PCP process. Administrative staff of the DMRDD Regional Center approves the services on-line as recommended by the Utilization Review Committee. A computer printout of the IPC can be generated by the DMRDD Regional Center as needed.

The automated system that creates the IPC has edits to ensure data integrity such as correct dates and mathematical calculations. Quality content is further ensured with random sampling of IPCs and PCPs for review by staff from the Division of Medical Services and by a Qualified Mental Retardation Professional (QMRP) in the DMRDD Central Office.

The individual plan of care, subject to federal, DMS and DMH audit, specifies the following:

- Units of service by month;
- Period of service;
- Provider of each service;

- Total cost of the plan; and
- Approval by the (DMRDD) Regional Centers

14.7 MEDICAID WAIVER CHOICE STATEMENT

When a person is evaluated as needing the level of care provided in an ICF/MR and the individual's Utilization Review score is at a priority level that warrants immediate service, the case manager informs the person or a legal guardian of any feasible community alternatives available through a MRDD waiver and gives the person the choice of either institutional or home and community-based waiver services. If the participant or legal guardian chooses to participate in a recommended waiver (Comprehensive, Community Support or Missouri Children with Developmental Disabilities/Sara Jian Lopez Waiver), a Medicaid Waiver Choice Statement (DMH-7833) ***must*** be signed and dated by the individual or a legal representative prior to services commencing. The service coordinator also signs and dates the Waiver Choice form. This form must identify the specific MRDD Home and Community–Based Waiver Program in which the individual will participate. Ensuring the choice statement is completed and the document is maintained is the responsibility of the DMRDD Regional Center, Affiliated Community Service Provider (ACSP), or County SB-40 Board that is providing service coordination.

14.8 MEDICAID WAIVER CHOICE OF PROVIDER STATEMENT

When more than one provider of service is enrolled as a waiver provider for a particular geographic area, the participant or legal guardian *must* be given a choice among eligible providers. The Client Choice of Provider Statement is used for this purpose. Choice among providers may be limited only if a participant's needs are so highly specialized that only a specialized provider can meet those needs. The limitation *must* be documented in the participant's record. The DMRDD Regional Center, Affiliated Community Service Provider (ACSP), or County SB-40 Board that is providing service coordination is responsible for ensuring Client Choice of Provider Statements are obtained and are maintained in the individual's case record.

14.9 PARTICIPANT RIGHTS TO DUE PROCESS

Medicaid rights of due process are extended to persons who participate in MRDD Home and Community Based Waivers. Participants have the right to appeal anytime adverse decisions are made or actions are taken. Some examples of adverse action that may be appealed include:

a) a participant is denied participation in the waiver;

b) a participant requests a waiver service but authorization is denied;

c) services or units of service are reduced without written approval of the consumer or guardian; or

d) a participant is determined no longer eligible for the waiver.

When adverse action is necessary, the case manager employed by the DMRDD Regional Center, County SB-40 Board or Affiliated Community Service Provider (ACSP) is responsible for notifying the participant in writing at least 10 days prior to any action being taken. Individuals have appeal rights through the Department of Mental Health and Department of Social Services, Division of Medical Services. While *not* required to do so, waiver participants are encouraged to begin with the Department of Mental Health's appeal process. The individual may, however, appeal to the Department of Social Services, Division of Medical Services, before, during or after exhausting the Department of Mental Health process. (See 13.17.D of this manual for more information on appeal rights and processes.).

Once an individual begins the appeal process through the Department of Social Services, the appeal process through Department of Mental Health shall not begin, or if in process will terminate since the Department of Social Services is the single state Medicaid Agency and any decision through that agency would supercede a decision made by Department of Mental Health. The individual is informed of the appeal process in a written notice. If the adverse action concerns termination or reduction of services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If the result of the agency's decision is upheld, the participant may be required to pay for the continued services. If the agency's decision is overturned, the participant is *not* responsible for the cost of services.

Complete information regarding the appeals process may be obtained from the DMRDD Regional Center, Affiliated Community Service Provider (ACSP), or County SB-40 Board case manager. The case manager assists participants as needed in requesting an appeal and preparing for the hearing.

END OF SECTION

Revised 1/07